NCSL OPIOID POLICY FELLOWS KICKOFF MEETING: BUILDING STATE LEADERSHIP

STATE STRATEGIES TO PREVENT AND INTERVENE EARLY
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KEY STRATEGIES

- Naloxone
- Prescription Drug Monitoring Programs (PDMPs/PMPs)
- Emergency Commitment
- Voluntary Non-Opioid Directives

INCREASING NALOXONE USE FOR OVERDOSE PREVENTION

- 50 states and D.C. have naloxone access laws
  - ✓ Expands dispensing/distribution of naloxone

Types of Expansions

- Who can receive naloxone
  - ✓ Family and friends
  - ✓ First responders
  - ✓ Community-based organizations, especially those who provide services to individuals at high risk of overdose

  - ✓ School nurse or other school employee that administers medication
  - ✓ Addiction treatment programs
  - ✓ Probation or parole officers
  - ✓ Offenders with history of drug and alcohol problems upon release from prison, jail, or correctional confinement
  - ✓ Syringe service programs

- Who can dispense/distribute naloxone
  - ✓ Community organizations, e.g., Overdose Education and Naloxone Distribution Programs

Methods of Dispensing/Distribution

- Third-party prescriptions
- Standing orders and protocol orders
- Collaborative practice agreements

Results of Expanded Access

- November 2018 – *Opioid overdose laws association with opioid use and overdose mortality,* McClellan et al.
- Associated with reduction in opioid overdose deaths
  - ✓ Decreases: 14% overall; 23% African Americans
- No increases in non-medical opioid use

Co-prescribing

- Gap remains in naloxone availability
  - ✓ < 1% of patients for whom clinicians should consider co-prescribing naloxone actually receive a naloxone prescription
- U.S. HHS recommendations for co-prescribing
  - ✓ Certain patients with opioid prescriptions
    - ➢ ≥ 50 daily Morphine Milligram Equivalent
    - ➢ Respiratory conditions
    - ➢ Concurrent benzodiazepine prescription
    - ➢ Non-opioid substance use disorder, excessive alcohol use or mental health disorder

- ✓ Patients at high risk for opioid overdose
  - ➢ Using heroin, illicit synthetic opioids, misusing prescription opioids
  - ➢ Using other illicit drugs
  - ➢ Receiving treatment for opioid use disorder
  - ➢ History of opioid misuse and recently released from incarceration or other custodial settings

- State laws – encourage or require co-prescribing
  - ✓ E.g., AZ, CA, FL, LA, VT, VA

Funding

- Increased demand = increased cost
  - ✓ Evzio - $4,100; Narcan $125 retail, $40 per dose

- Federal options
  - ✓ FDA paving way for over-the-counter sales
  - ✓ Work to extend labeled shelf life
    - ➢ Current labeled expiration – 18-24 months
    - ➢ Nov. 2018 study results – Asst. Prof. Charles Babcock

- Naloxone can be used well past expiration date
- Ezvio – usable 12 months after expiration date
- Narcan – usable 10 months after expiration date

✓ State options
- Improve Medicaid and commercial insurance reimbursement
  - ❖ Take-home naloxone
  - ❖ Devices needed for administration
  - ❖ Refills
  - ❖ Pharmacy administration fees
  - ❖ Time spent counseling or training

Reporting of Naloxone Information

- Some states require practitioners to report non-fatal overdose information to state and/or local health officials
  - ✓ E.g., AZ, NV, NM, RI, TX
  - ✓ State systems for timely reporting specified diseases or conditions
    - Add overdose to list
- Some states require reporting to PDMPs
  - ✓ E.g., AZ, OR, VA, WV, WY
- Unintended consequence
  - ✓ Denial of insurance for receipt of naloxone
  - ✓ State law amendments – prohibit denial

TRANSFORMING PDMPS INTO BETTER HEALTH CARE TOOLS

- Lingering themes - original criminal justice development
  - ✓ Focus on controlled substance prescriptions
  - ✓ Healthcare access limited to prescribers and dispensers
  - ✓ Access by individuals for use by individuals
  - ✓ Health care access dependent on direct patient relationship
  - ✓ Intrastate data collection
  - ✓ Presentation in long list of prescriptions dispensed
  - ✓ Voluntary use

More Comprehensive Data

- All prescriptions
  - ✓ NE
- Diagnosis codes
  - ✓ ICD 10
  - ✓ E.g., ME
- Noncontrolled/nonscheduled substances
  - ✓ 28 states, D.C. and Guam
  - ✓ Gabapentin, e.g., MA, MN, NJ, ND, OH, VA, WV

- Non-prescription data
  - ✓ Overdose deaths – E.g., NV, OK, TN, UT, WI
  - ✓ Instances of opioid-related overdoses – E.g., KY, WV, WI
  - ✓ Convictions for DUI/DWI – E.g., UT
  - ✓ Convictions for violations of controlled substances or prescription drug laws – E.g., KY ,UT
  - ✓ Suspected violations of controlled substances or prescription drug laws – E.g., WI
  - ✓ Reports of stolen prescriptions – E.g., NV, WI
  - ✓ Patient's voluntary non-opioid directive – E.g., RI

Data Sharing with Health Care Professionals

- Sharing beyond individual prescribers/dispensers for patient care
  - ✓ Delegates
    - ➢ Prescriber/dispenser liable for delegate activities
    - ➢ Prescriber/dispenser must make patient care decision
    - ➢ More focus on allowing unlicensed professionals
  - ✓ Substance abuse treatment counselors/specialists
    - ➢ 17 states
    - ➢ E.g., MD, ND, UT, WI
- Sharing with institutional users
  - ✓ Hospitals, health care facilities, group practices
  - ✓ E.g., KY, IN, IA, MT, WA State

- Sharing beyond jurisdictional boundaries – interstate
  - ✓ All states but NE have legal authority
  - ✓ 45 states, D.C. and Puerto Rico engaged in sharing
  - ✓ Max # of jurisdictions with which a state shares data – 38 (37 plus DC)

- Sharing with health/pharmacy IT systems
  - ✓ Focus on EHRs, HIEs
  - ✓ 26 states
    - ➢ Statutory/regulatory language allows integration or interoperability
  - ✓ States with no specific language
    - ➢ interpretation allows integration or interoperability

- ✓ Governance laws/rules for PDMP data and other patient health data can differ
  - ➢ Authorized users
  - ➢ Methods of access
  - ➢ Purposes of access
  - ➢ Storage and retention
  - ➢ Presentation to end user
  - ➢ Disclosure and use in health system
  - ➢ Audit trail – who requests patient data

- ✓ PDMP statutes/regulations – restrictions over and above HIPAA
  - ➢ PDMP not a covered entity
  - ➢ PDMP not a business associate of a covered entity

- ✓ State alignment of governance laws and rules for PDMP and other patient data
  - ➢ Placement/storage of PDMP data/report in medical or health record
    - ❖ 17 states plus FL proposed rule
  - ➢ Access, disclosure and/or use rules applicable to other patient health information in medical or health record apply to stored PDMP data
    - ❖ 7 states – CA, CO, KY, NJ, TN, TX, WA State

- Sharing for public health surveillance
  - ✓ Release of de-identified data for statistical, research, policy, education
    - ➢ All but 5 states – AL, MN, MI, NE, NY
    - ➢ D.C., Guam, and Puerto Rico

- ✓ Specific language for access
  - ➢ E.g., Toxicologists, epidemiologists
  - ➢ E.g., Conduct of scientific studies, analysis as part of duties, or public health responsibilities
  - ➢ E.g., Death fatality review teams

Clinical Decision Support

- Alerts/unsolicited reports to prescribers re: patients
  - ✓ 35 states
  - ✓ Proactive notice of concerning patient behavior
    - ➢ E.g., ≥ specific daily MME
    - ➢ E.g., concurrent opioid and benzodiazepine prescriptions
    - ➢ E.g., visits to specific # of prescribers and/or pharmacists in a specific time period

- Practitioner led alerts
  - ✓ E.g., IN, WI
- Proprietary PDMP data interpretations or visualizations
  - ✓ E.g., risk scores
  - ✓ No state bars development or use of interpretations like risk scores
  - ✓ Challenge for PDMP Administrators
    - ➢ Algorithms/criteria are undisclosed so can't assess if accurate representation of PDMP data/report
    - ➢ Some states beginning to issue legal opinions that review of interpretations are not compliance with mandated use provisions
      - ❖ E.g., KY, VA

- Educational resources
  - ✓ E.g., summaries or links to CDC and state prescribing guidelines
- Patient referral button/treatment locator
  - ✓ E.g., link to SAMHSA or state single state authority list of treatment resources
  - ✓ E.g., enhancements to display available beds and 3rd party payer information

Prescribing Practice Improvement

- Prescriber report cards, peer review reports, practice insight reports

- ✓ Comparative peer information re: prescribing practices and patient population data
  - ➢ 24 states, D.C., and Puerto Rico
- ✓ Types of peer comparisons
  - ➢ Prescriber's number of milligrams per month compared to peer averages by specialty
- ✓ Types of patient risk factors
  - ➢ Number of patients receiving designated Morphine Milligram Equivalents or more per day
  - ➢ Number of patients filling prescriptions at designated # of pharmacies
  - ➢ Number of patients obtaining refills
- ✓ PDMP or practitioner generated

- Access by Chief Medical Officers, medical directors or medical coordinators
  - ✓ E.g., WA State, WV, WI
  - ✓ Review of prescribing practices for practitioners under management or supervision
  - ✓ Intervene to educate or help adjust possible outlier or inappropriate prescribing before matter becomes issue for licensing board

Mandated Use

- States and territories
  - ✓ Prescriber – 43 states and Guam
  - ✓ Dispenser – 21 states

- General circumstances that trigger prescriber's requirement to check
  - ✓ Initial prescribing of designated substance
  - ✓ Each prescribing of designated substance
  - ✓ Prescribing for treatment of pain
  - ✓ Prescribing for treatment of drug addiction
  - ✓ Prescribing in worker's compensation cases
  - ✓ Prescribing when reason to believe substance is sought for illegal or non-medical purposes

INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDERS

- 37 states plus D.C. have laws

- Common concerns
  - ✓ Not enough treatment for those who want to enter treatment let alone those who are forced
  - ✓ Many treatment facilities are unsecured
  - ✓ If individual forcibly committed leaves, commitment damages trust
  - ✓ Violates civil liberties

- Parents and family members
  - ✓ Last opportunity to save loved one

- Laws vary in detail but have key themes
  - ✓ Application to court
  - ✓ Individual to be committed afforded due process
  - ✓ Persons who can initiate application
    - ➢ Spouse or other relative
    - ➢ Guardian
    - ➢ Law enforcement officer
    - ➢ Designated health professional or responsible person
  - ✓ Burden of proof is clear and convincing evidence
  - ✓ Criteria in all states
    - ➢ Danger to self or others
    - ➢ Danger to self includes inability to provide for basic needs; refuse to take care of him/herself

  - ✓ Additional criteria in some states
    - ➢ Impaired judgment
    - ➢ Gravely disabled
    - ➢ Incapacitated
    - ➢ Loss of self-control over substance use

- Emergency commitment
  - ✓ Short-term
    - ➢ E.g., Maximum of 72 hours or less
  - ✓ Stabilization and assessment purpose
  - ✓ Apply to treatment program who agrees to consider commitment application
    - ➢ Before application to court
  - ✓ Same applicants to court can apply to treatment program

- ✓ Qualified clinical professional certifies in writing that criteria for commitment are met
- ✓ Criteria modifications
  - ➢ E.g., danger to self or others must be immediate
  - ➢ E.g., unable to obtain court order in time to prevent immediate danger
- ✓ Medical and drug and alcohol assessment may be conducted
- ✓ Committed individual can leave at any time and must be let go at end of maximum commitment time unless court or statute allows continued commitment

VOLUNTARY NON-OPIOID DIRECTIVES

- State laws allow patient to refuse treatment with opioids
  - ✓ E.g., AK, CT, LA, MA, PA, RI
- Placed in medical record and sometimes PDMP
- Patient can revoke at any time for any reason by oral or written means
- Immunity for health professionals who comply
- Some states provide exemptions
  - ✓ E.g., emergency
  - ✓ E.g., override by guardian or health care proxy

QUESTIONS?

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